



The  
**pda**  
Road Map

July 2012

# Review of NHS Pharmaceutical Care of patients in the community in Scotland

Road Map proposals

A submission by the Pharmacists' Defence Association

| defending **your** reputation |



# Foreword

## The PDA's Road Map Proposals

For many years, the widely held view about community pharmacists is that they are an extremely valuable but often underutilised resource. Although the vast majority of community pharmacists are working extremely hard and are increasingly delivering an ever wider range of valuable services to the public, often they are not able to direct the majority of their efforts to the things that would add greatest value to servicing the health needs of their patients.

The reasons for this are multifactorial, but are possibly best summed up by the following sentiment;

*"In the UK, community pharmacists are seen as shop keepers and do not even have access to the diagnosis upon which the prescription has been based. What a waste of professional expertise and what a reflection on our governmental systems that, purely for historical reasons, necessary change has not been driven forward."*

Hugh McGavock Professor of prescribing science  
ex member of Committee on Safety of Medicines

The Scottish Government has taken a decisive move and has made clear that it seeks to enhance the pharmacist's clinical role and make the necessary changes to optimise the role of Pharmaceutical Care in the community so as to achieve sustainable, high quality healthcare through a greater integration of the healthcare team.

We greatly welcome and wholeheartedly support this development.

A hundred years ago, pharmacists were more likely than not to be an owner of a pharmacy; only a small percentage of pharmacists being employees. Today, only a minority of pharmacists own a pharmacy with 90% being employees or locums. Our members are not the owners of pharmacy businesses and they are unlikely to have made a significant financial investment in the purchase of a pharmacy, they are however, the employee and locum pharmacists who each day, find themselves at the very cutting edge of direct patient care. As such, theirs is an investment in professional and intellectual skill and expert knowledge. This is a hugely important and valuable asset, the very asset that has been hitherto underutilised and which the NHS must now harness for the benefit of patients.

Pharmaceutical Care is a patient centred practice in which the practitioner assumes responsibility for a patient's medicines related needs and is held accountable for this commitment.

The majority of our members relish the prospect of being able to deliver Pharmaceutical Care and take greater responsibility and accountability for their patients. However, many of them tell us that to be able to do this properly, they need to be able to practice with much greater professional autonomy and flexibility than they currently enjoy and in a way that enables them to fully utilise their knowledge and expertise through the development of clinical relationships with patients.

This submission builds strongly upon that ambition and proposes ways in which this can be achieved whilst producing much improved health outcomes for patients.

We believe that this important review is a major opportunity to develop new and improved contracting arrangements which would see pharmacy making a more comprehensive and powerful contribution to the delivery of the Governments 20:20 vision of providing sustainable high quality healthcare for the Scottish people into the future.

**Mark Koziol**  
**Chairman**  
**The Pharmacists' Defence Association**



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# Review of NHS Pharmaceutical Care of patients in the community in Scotland

## The PDA's Road Map proposals

### > Section 1 – Introduction

This section explains who the Pharmacists' Defence Association (PDA) are and provides a high level overview of our proposals and the thinking that underpins them.

#### Who are we?

- 1.1** The Pharmacists' Defence Association (PDA) is a not for profit defence association and trade union for pharmacists. Our aim is to support the needs of individual pharmacists by representing their interests and, when necessary, defending their reputation. The PDA is the only organisation that exclusively looks after the interests of employee and locum pharmacists across all sectors of pharmacy, and it currently has an increasing membership of more than 19,000 individual pharmacist members, of which over 1,700 are in Scotland.
- 1.2** The PDA's primary aims are to:
- Support pharmacists in their practice, employment and legal needs
  - Provide representation for its members
  - Proactively seek to influence the professional, practice and employment agenda so that members can deliver high quality care
  - Lead and support initiatives designed to improve the knowledge and skills of pharmacists towards improved risk management, safer practice and high quality patient care
  - Work with like-minded organisations to deliver these aims
  - Provide insurance cover to safeguard and defend the reputation of the individual pharmacist.
- 1.3** The activities of the PDA lead it to experience a large number of critical conflict incidents where it is required to provide support to PDA members. This largely occurs in the areas of employment conflicts, professional regulatory incidents, civil claims for compensation and criminal proceedings against

pharmacists. This provides the PDA with a rich and unique vein of up to date experience that informs its policies and future trajectory. The proposals put in this submission are largely built upon this experience and are blended with the general direction of travel of healthcare policy in Scotland.

#### Our Road Map proposals – a summary overview

- 1.4** We welcome the opportunity to submit our proposals to this review initiative in Scotland. We have been developing our thinking for strategic change in community pharmacy over the last two years and we have called this initiative the PDA Road Map. Whilst much of our work has been in the whole of UK context, the strategic direction in this submission is very much from a Scottish perspective.
- 1.5** There are three key areas of thinking that underpin the PDA proposals. Firstly there is the current underutilisation of the skills of primary care healthcare team members, including GPs, but especially pharmacists' clinical skills in dealing with the public. In part this is seen as a consequence of the current pharmaceutical service contracting arrangements. They have been largely in place for over 20 years and until relatively recently, when the concept of Pharmaceutical Care services was introduced, focused largely on the act of dispensing prescriptions. Over time the shift has been from contracts held by independents to contracts held predominantly by large corporate pharmacy multiples, supermarkets or chain stores. And with that has come an increasing focus on commercial/ financial return factors, rather than the provision of professional or clinical services for the benefit of patients and the public at large.

- 1.6** Secondly, the lack of collaboration and integration between community pharmacy and general medical services, which has led to failures in continuity of patient care leading to unnecessary hospital admissions and increased adverse drug reactions/ medicines wastage.
- 1.7** Thirdly, our proposals are also predicated on a much more efficient and effective use, by both the NHS and patients, of the physical buildings that currently make up GP surgeries and community pharmacies.
- 1.8** In short, the PDA proposal is for Pharmaceutical Care Services (PCS) to be provided through a separate contractual mechanism that is independent of the current community pharmacy contract for medicines supply. These specialist Pharmaceutical Care services would be provided by a new two tier categorisation of community pharmacists, i.e. 'patient facing' and 'clinic' pharmacists. The focus of this proposal would be to enable the 'patient facing' pharmacist to provide a reactive and proactive service to patients walking into the pharmacy without an appointment, and for the 'clinic pharmacist' to provide more detailed Pharmaceutical Care services to people with long term conditions (LTCs) on a registered patient appointment-led basis.
- 1.9** The 'clinic pharmacist' in particular would provide a range of professional and specialist PCS that at present are largely handled in general practice. And it's that transfer of service responsibility and accountability to release GP capacity that is at the core of these proposals. This will enable GPs to use their skills to much better effect by providing greater front line attention to patients with more complex conditions, or those 'at risk' of hospital admission.
- 1.10** Delivery of this vision will require genuine collaboration, integration and then contractual alignment across the medical and pharmaceutical professions in primary care. It will be supported by the already much more clinically orientated education and training of pharmacists at both undergraduate and practice levels. This vision will also need to be linked to revised mechanisms for service provision and workforce planning. This submission includes proposals to these ends and, importantly, to ensure that the benefits of the new approach extend to the areas of residential care homes and persons living in remote and rural areas.

- 1.11** The submission has been split into sections. Some issues or topics will feature in one or more sections, so for ease of reference the section summaries are collectively provided below.

**Section 1 – Introduction:** explains who the Pharmacists' Defence Association (PDA) are and provides a high level overview of the proposals and the thinking that underpins them.

**Section 2 – Background:** sets out the financial and strategic background against which the PDA proposals have been developed, and the need for change to the current community pharmacy contractual arrangements.

**Section 3 – Foundations for the PDA Road Map:** sets out the basic tenets upon which the PDA Road Map is built. It highlights the need for multidisciplinary co-operation in the primary care sector, provides a definition of Pharmaceutical Care services, and summarises the pharmacy workforce structure to underpin their delivery.

**Section 4 – Utilising released and new healthcare service capacity:** expands on how and where the released and new service capacity outlined in Section 3 could be utilised. It describes how that capacity should be used to improve care regimes for patients with long term conditions and increase the focus on preventing hospital admissions, through a combination of close monitoring of 'at risk' patients, adopting a 'virtual ward' approach, and reducing the incidence of adverse drug reactions and medicines wastage.

**Section 5 – Contracting for Pharmaceutical Care Services:** argues the case for new contractual arrangements in primary care, based on the need for clear professional autonomy and the removal of conflicts between a contractor's professional and commercial interests. It calls for separate contracts for supply and Pharmaceutical Care services, sets out the principles underpinning this approach, and provides a number of contract models for delivering Pharmaceutical Care services.

**Section 6 – Other contracting issues:** expands on Section 5 by detailing a number of specific issues that should be addressed through health boards' overall contract and service planning arrangements. These are:

- The need to make better use of, and to further develop, the effectiveness of the existing pharmacy premises network
- Greater cross-collaboration between pharmacies and collaboration with dispensing doctors
- Improved service availability and access in remote and rural areas
- Dedicated PCS for people in residential care homes
- 'Clinic pharmacists' accredited in the delivery of specialist services.

**Section 7 – Information sharing and IT:** endorses Royal Pharmaceutical Society (RPS), Royal College of General Practitioners (RCGP) and British Medical Association (BMA Scotland) statements regarding the need for GP/pharmacist collaboration in redistributing the workload for the benefit of patients and in working more closely on integrated training and service development. It considers sharing patient data, further IT development of data access and transfer facilities, and provides a number of IT development areas worthy of priority for pharmacy and wider NHS use.

**Section 8 – A patient focus:** summarises the patient benefits that would accrue from the introduction of 'clinic' and 'patient facing pharmacist' services and consequential increase in GP capacity. It supports the complementary development of 'pharmacy walk-in services', and outlines the patient safety needs in terms of self-care and the community pharmacy environment.

**Section 9 – Workforce, education and training:** outlines the current workforce position and the need to build upon current pharmacy education and training to underpin the PDA's proposed Road Map approach. It describes a clinical career pathway and its postgraduate support and development requirements, and the need for these to be on a multidisciplinary footing with other healthcare professionals. Finally it outlines the education and training needs for pharmacy technicians and support staff.

**Section 10 – Finance:** sets out to demonstrate the considerable financial headroom within which the concepts described in the PDA Road Map proposal may operate. This section is not a definitive financial assessment of the exact financial impact, rather it is a financial indicator of how a more integrated delivery of healthcare and the application of Pharmaceutical Care can deliver very considerable improvements in the efficiency of the NHS in Scotland.

This analysis is based on the assumption that these proposals will, along with other review submissions, be subject to detailed cost analysis within the Health Department.

## > Summary of the main recommendations

The following is an edited summary of the underpinning key recommendations:

1. Pharmaceutical Care is defined as:

**“A patient-centered practice in which the practitioner assumes responsibility for a patient’s medicines-related needs and is held accountable for this commitment.”**<sup>1</sup>, (Paragraph 3.8)

2. There needs to be a fundamental enhancement in the current skill mix and workforce structure within community pharmacy resting on three categories of personnel, i.e. registered pharmacy technician, patient facing pharmacist and clinic pharmacist (working within a structured career/quality framework). (3.12)

### Planning (Sections 3 and 6). We recommend:

3. The early introduction of Pharmaceutical Care Needs Plans (PCNPs) – arrangements that take account of the contract and service provision changes that result from the current review (3.13); and...

4. That the PCNPs identify where, in geographical terms, the services of clinic pharmacists should be made available to the public, stipulating the number and grade requirements to meet both general Pharmaceutical Care services (PCS) and the more specialist patient needs. (3.14)

5. Pharmaceutical Care Services needs are detailed under three main categories over and above the act of dispensing (the Acute Medication Service or AMS), i.e. Minor Ailments Services (MAS), Public Health Services (PHS) and Chronic Medication Services (CMS). (3.17)

6. Over and above the current arrangements, CMS should specifically detail two distinct areas which would be provided exclusively by appropriately graded ‘clinic pharmacists’. These are patients in the community who have relatively stable long term conditions (LTCs), and patients in residential care homes. (3.18, 3.19, 6.9, 6.10)

7. The PCNPs should also provide for one or more clinic pharmacists to serve a wider geographical area by working across a number of pharmacies, and even other locations such as residential homes on different days. (6.5)

### Utilising released and new healthcare service capacity (Section 4). We recommend:

8. Clinic Pharmacists to build up a list of registered patients and develop CMS through Pharmaceutical Care by either GP referral or direct patient registration. (4.2, (4.12) and that;

9. CMS is taken forward through a combination of new contractual structures that seek to make individual pharmacists (and not large commercial organisations) both responsible and accountable for patients’ Pharmaceutical Care needs, and promote more integrated and collaborative working between GPs, pharmacists, and other members of the primary healthcare team. (4.4)

### Incentives to reduce hospital admissions

10. That the 2012 QOF initiative to produce plans for reducing hospital admissions should be further encouraged by being subject to continuing QOF or healthcare quality targets. GP’s should be incentivised via the QOF system to refer patients with LTCs to suitably qualified clinic pharmacists. (4.6)

### Avoiding hospital admissions through greater access to urgent care

11. Surgeries should become more orientated to handling acute presentations; (4.7) and that...

12. The initiative as a whole is incentivised through new and improved contractual arrangements for GPs – supported by a strategy and funding to provide for the establishment or upgrading of suitable premises; (4.7) and thereafter...

13. Availability of GPs’ urgent care service is subject to a high profile public information campaign. (4.7)

### Preventing hospital admissions through smarter care of patients

14. Use enhanced general practice capacity in a proactive way to operate a virtual ward approach across the whole of Scotland; (4.8, 4.9, 4.10)

15. A clinic pharmacist is actively involved in the virtual ward team, (4.9) aided by...

#### References

1. Cipolle RJ, Strand LM, Morley PC. Pharmaceutical care practice: the clinicians guide. 2nd ed. New York: McGraw-Hill; 2004.

16. The national development of a combined predictive tool/model to underpin the necessary risk stratification requirements. (4.11)

17. GPs to refer patients already diagnosed with LTCs to suitably qualified clinic pharmacists and that the QOF point system for GPs is used to incentivise this. (4.6, 4.12, 10.2)

### **Reducing adverse drug reactions through Pharmaceutical Care**

18. Clinic pharmacists through Pharmaceutical Care to provide educational information, medicines use optimisation services and support to patients enabling them to take greater control of their medicines regimes. (4.16)

### **Reducing medicines wastage through Pharmaceutical Care**

19. Emphasis should be on health outcomes rather than waste reduction alone. (4.22) To this end...

20. Future QOF indicators proposed at (4.6), and outcome measures in both the GPs' and community pharmacy contracts, should focus initially on the following therapeutic areas: asthma, diabetes, raised blood pressure, vascular disease and care of people with schizophrenia. (4.21, 4.22)

### **Contracting for Pharmaceutical Care Services (Section 5): We recommend –**

21. Contracts for detailed Pharmaceutical Care services should rest either with individuals who are pharmacists – some of whom may also be the owners of pharmacies – or with vehicles that are independent of the corporate retailing culture that currently prevails within community pharmacy. (5.7) And...

22. Such contracts should, through commissioning principles, commit contractors to high standards of professional healthcare delivery, (5.7)

23. Separating the contract for supply (and those services directly associated with the supply) from the contract for the delivery of Pharmaceutical Care services (5.8).

**Note – a full list of recommended principles to underpin this contractual approach is found at 5.12.**

### **Other Contracting Issues (Section 6).**

#### **We recommend:**

24. The creation of a modernised pharmacy network through the further development of consultation rooms in community pharmacies to host a wide range of healthcare services. (6.2)

25. Collaboration between clinic pharmacists and community pharmacies in terms of shared access to, and between, pharmacy premises. (6.3 and 6.4)

26. Clinic pharmacists operating within a graded structure should be accredited to practice in a range of specialist programmes e.g. end of life care, palliative care, substance misuse, diabetes etc. Health Boards' PCNPs plans should identify where such specialist services are required. (6.12, 6.13)

### **Information sharing and IT (Section 7).**

#### **We recommend:**

27. Community pharmacists to have formal IT access to key patient records that lie outside the pharmacy, e.g. laboratory results, discharge letters, etc. (7.1)

28. Increased sharing of patient information between general practice and pharmacists. (7.2)

29. Integrated patient care records available for both primary and secondary care that are readily accessible through IT to all appropriate healthcare providers. (7.2)

### **Workforce, education and training (Section 9).**

#### **We recommend:**

30. Redesigning pharmacy training via a new five year training programme that seeks to integrate work placement, educational teaching and practical patient-facing clinical experience, as well as training which is more integrated with that provided to future doctors and nurses. (9.10)

### **A clinical career in community pharmacy**

31. The introduction of a structured career framework in community pharmacy with financial incentives for skills and competency development through training. (9.11)

32. Pharmacists being able to work at practitioner, advanced practitioner, specialist and consultant levels. (6.12, 9.13)

### **Postgraduate development**

33. Community pharmacists have ready access to a central resource centre coupled to ongoing support and peer review access to maintain and develop specialist skills and career progression. (9.14)

34. Widen the current approach for support and peer review to include other health professionals as the delivery of community care becomes more collaborative and integrated. (9.16)

**Finance (Section 10). We recommend:**

**35.** A nationally co-ordinated and well promoted media campaign, should aim to transfer 40 per cent of GP minor ailment consultations to community pharmacies, i.e. 34,600 consultations per week. (10.5)

**36.** The clinic pharmacist service would rely on LTC patient registration via GP and wider care pathway referrals. The additional capacity created for GP's would need to be used to re-orientate their services to make them more responsive to acute presentations. (10.2)

**37.** The management of a wider transfer of patients with minor ailments from GPs to pharmacists would require some investment in the pharmacy workforce through skill mix to allow registered pharmacy technicians to deal with the mechanics of dispensing, whilst releasing pharmacists to be able to spend most of their time in a much more patient facing role. (10.6)

**38.** The PDA's Road Map proposals are subjected to detailed cost analysis within the Health Department. (10.17)

## > Section 2 – Background

This section sets out the financial and strategic background against which the PDA proposals have been developed, and the need for change to the current community pharmacy contract arrangements.

### Healthcare – the big picture

- 2.1** The Scottish Government's strategic '20:20 Vision' narrative on future healthcare needs in Scotland<sup>2</sup> states that over the next 10 years the proportion of over-75s in its population – who are the highest users of NHS services – will increase by over 25 per cent. By 2033 the number of people over 75 is likely to have increased by almost 60 per cent. There will be a continuing shift in the pattern of disease towards long term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia.
- 2.2** The Government's healthcare budget for 2012-13 is £11.6 billion, an increase of 1.85 per cent on the previous year. Whilst NHS resource funding will continue to increase, issues such as the ageing population, new technology and the cost of drugs mean that the NHS will still face considerable budget pressures. Over the next 20 years demography alone could increase expenditure on health and social care by over 70 percent<sup>3</sup>.
- 2.3** The Government's 2012-13 budget statement states public expenditure will fall in real terms in the period to 2014-15, but that the revenue position for the NHS has been relatively protected. However, that vital protection needs to be seen in the context of the global pressures on health spending. To meet those pressures, health boards are working this year to deliver cash releasing savings of £300 million to be retained locally<sup>4</sup>.

### Family Health Services (FHS)

- 2.4** The cost of FHS in 2010-11 was £2.4 billion, of which £1.9bn was on General Medical Services (GMS) and Pharmaceutical Services. A further £0.075 billion was spent on provision of out of hours cover within community services<sup>5</sup>. This is a considerable proportion of the overall healthcare budget and, together with the Government's Quality Strategy objectives, presents a significant challenge in considering the future service and contractual needs for community pharmacy and GMS.

### Community pharmacy contracts

- 2.5** Today more than 90 per cent of pharmacists are either employees or self-employed locums, and only a very small minority of pharmacists actually own a community pharmacy<sup>6,7</sup>. This means that the professional skills and ambitions of many community pharmacists may well be restricted by the commercially conflicting interests of their employers. Therefore the PDA approach is radical in parts and freed from the desire to protect existing business models. Nevertheless, we share substantial common ground with the pharmacy bodies that represent contractors and our proposals are predicated on the need for a strong community pharmacy network and, fundamentally, building on the firm base on which the service model in Scotland already rests.
- 2.6** At a macro level the current community pharmacy contract arrangements in Scotland, as with the rest of the UK, comprise two combined elements – the procurement, dispensing and supply of prescribed medicines, and the provision of professional pharmaceutical advice as and when required. It has been this way for over 20 years, albeit with operational and service enhancements introduced by the government along the way. In particular, successive governments have:

#### References

2. Achieving Sustainable Quality in Scotland's Healthcare – A '20:20' Vision. Scottish Government, 2011.
3. Scottish Spending Review 2011 & Draft Budget 2012-13. Scottish Government, September 2011.
4. Ibid.
5. Scottish Health Service Costs year ended 31st March 2011. Information Services Division, November 2011.
6. Seston E, Hassell K. Pharmacy Workforce Census 2008: Main findings. RPSGB, 2009.
7. Register of Pharmacy Premises. General Pharmaceutical Council, 2012.

- Incrementally honed medicines procurement and GP prescribing practices to secure better value for money and at the same time deliver more effective patient outcomes
    - Made considerable financial investment in pharmacies' infrastructure, notably in premises improvements and the provision of IT hardware and software
    - Developed the concept of additional services that have been provided alongside the supply function, i.e. services that are more patient focused with emphasis placed on providing professional advice/support on a wide range of health and illness related issues.
- 2.7** So, on the face of it the current community pharmacy services arrangements in Scotland are far from broken. In fact it could be argued that they are the best in the UK. However, significant weaknesses remain in the system:
- (i) The potential conflict between a contractor's professional and commercial interests – particularly in the case of contracts held by large corporate multiple or chain stores, many of whom are also wholesalers, some of whom are supermarkets, and in one case backed by a venture capital company. The risk is that services are delivered in such a way as to achieve maximum financial return, rather than in a way that truly matches individual patient needs and those of the wider healthcare service in Scotland. This in turn can result in employee/employer conflicts and ultimately patient detriment.
  - (ii) Although in recent years there has been a change in emphasis, the contract's reimbursement and remuneration framework is still largely geared towards rewarding transaction volume rather than predominantly focusing on patients' care needs, service efficiency and quality.
  - (iii) Largely as a consequence of (i) and (ii), the intellectual and professional skills of individual pharmacists have been insufficiently utilised in delivering quality care and support at an individual patient level. This has generally mitigated against the development by pharmacists of clinical relationships with patients and also in the provision of continuity of care.
  - (iv) From an overall patient perspective, community pharmacy and general practice have failed to integrate or work collaboratively enough on care service design and delivery. In the main their respective contracts have been developed in separate silos. The consequence is an underutilisation of their respective professional skills, meaning they focus more on routine matters than those that best serve the patient's journey, e.g. to spend more time with patients with complex or acute needs to optimise their use of medicines, thus preventing unnecessary hospital admission, reducing ADRs and minimising medicines wastage.
  - (v) Community pharmacy premises are underutilised for patient consultation purposes. With around 1,000 GP premises in Scotland and over 1,200 community pharmacies<sup>8</sup>, most with suitable patient consultation facilities – more effective use of the community pharmacy network could significantly improve in overall primary care capacity enabling both GPs and pharmacists to focus their unique skills in benefiting patients in a much more patient centred way.
  - (vi) The current community pharmacy contract arrangements make no special provision for the needs of people resident in care homes, or those who reside in remote or rural areas where no local community pharmacy or services are available.
- 2.8** But key is the fact that the intellectual and professional investment made by individual pharmacists in their practice is an extremely valuable asset that the NHS does not exploit sufficiently for the benefit of patients and the NHS generally. In the community pharmacy setting this is to the detriment of patients, the profession and the wider NHS.
- 2.9** Our proposals seek to encourage the existing corporate pharmacy model to deliver improved quality and outcomes. In part this will be through the development of significantly enhanced and more specialist clinical services led by appropriately qualified pharmacists who seek to develop much deeper clinical relationships and continuity of care with the patients they care for.

## References

8. ISD data.

## > Section 3 – Foundations for the PDA Road Map

This section sets out the basic tenets on which the PDA Road Map is built. It highlights the need for multidisciplinary co-operation in the primary care sector, provides a definition of Pharmaceutical Care Services, summarises the pharmacy workforce structure to underpin their delivery and the structure required to support it.

### Increasing capacity through innovation and collaborative working

**3.1** Core to our thinking is that the rate limiting factor to improving healthcare delivery in the community is a lack of primary care capacity. The consequence is increased pressure on the secondary care sector, which has its own capacity and cost issues. If clinical commissioning is going to deliver transformational change, a key part of the solution will be having flexible capacity to develop enhanced care services in both general practice and community pharmacy. However this will require, and we therefore recommend, more collaborative working between primary healthcare providers than has hitherto been the case.

**3.2** Pharmacy services have historically been designed and developed in isolation from other primary care services and with little involvement from GPs. To a degree, the same could be said with regard to general medical services and GPs' involvement with pharmacists. Either way, until recently constructive dialogue between the two professions has tended to be overshadowed by differences of opinion about, for example, dispensing rights and the scope of the Pharmaceutical Care services being introduced under the new community pharmacy contract, e.g. Minor Ailments Scheme (MAS) and Chronic Medication Services (CMS).

**3.3** It is therefore encouraging to see the February 2012 joint Royal Pharmaceutical Society (RPS) Scotland and Royal College of General Practitioners (RCGP) Scotland statement entitled 'Breaking down the barriers – how pharmacists and GPs can work together to improve patient care.'<sup>9</sup> It confirms that both professions are now coming to appreciate the potential benefits of closer and more integrated working and hence the need for greater communication between the two.

**3.4** In addition to a number of recommendations it identifies key 'building blocks' that need to underpin closer working between the two professions, notably:

- Increased sharing of patient information facilitated by improving inter-professional IT links with clear safeguards for consent and confidentiality
- GP practices and community pharmacies should work together to ensure consistency of service for the public
- Joint education and training at undergraduate and postgraduate levels to build greater trust and understanding of the professions' respective and complementary roles, skills and expertise. Both bodies will work together to explore continued opportunities for joint learning
- Acknowledging the importance for joint working to improve care, safety and better use of medicines.

**3.5** The British Medical Association (Scotland) recently undertook a comprehensive strategic review called 'The Way Ahead'<sup>10</sup> in which it consulted with a wide range of stakeholders to include patients. The consultation considered ways in which services to healthcare services to patients could be improved. Themes that this exercise was keen to develop included:

- Providing other healthcare practitioners with additional funding to absorb some of the demand on GP surgeries
- Transfer of routine prescribing to pharmacists to free up GP time
- Considering carefully the benefits of different contractual models
- Reducing the number of patients per practice list
- Transferring work from secondary to primary care and the closer involvement of GP surgeries in A&E care.

#### References

9. Breaking down the barriers – how pharmacists and GPs can work together to improve patient care. RCGP Scotland and RPS Scotland Joint Statement, 2012.

10. General Practice in Scotland: The Way Ahead – Final Report. BMA Scotland, 2010.

- 3.6** Building on these synergies is vital. For it is only by adopting a more collaborative approach across community pharmacy and general practice that significant additional capacity for primary care innovation, and delivery of services historically provided in secondary care, can be achieved.
- 3.7** A key aim in the PDA proposals is to see a reduction in unplanned patient attendances at hospitals. Ways to achieve this are covered in Section 4 but the basic tenet is to do so by increasing and using the skill capacity in the primary care sector much more effectively. Such a shift would release capacity in the secondary care sector, which would help the NHS in Scotland to take on the increasing demographic challenges on the near horizon. Ultimately, we seek to achieve this through service redesign and innovation, and a much better use of the highly skilled workforce and NHS resources generally.

### Pharmaceutical Care – a definition

- 3.8** As stated above, our aim is to see enhanced care services across the community care sector. From a community pharmacy perspective it is important to focus on what this means. To that end we rely upon the internationally accepted definition of Pharmaceutical Care:

**“A patient-centered practice in which the practitioner assumes responsibility for a patient’s medicines-related needs and is held accountable for this commitment.”<sup>11</sup>**

- 3.9** This is a review of Pharmaceutical Care, it is not a review of cognitive add on services, or a review of ‘supply plus’ style services. Pharmaceutical Care as properly defined is a detailed process based upon the development of a one to one clinical relationship between the patient and pharmacist. This is precisely the situation in which the unique knowledge possessed by the pharmacist can be properly deployed for the benefit of the patient. The care provided results in much more than just a referral back to the GP, since the Pharmaceutical Care provider assumes responsibility for the patient’s medicines-related needs. This means that the pharmacist involved must be able to practise at a level of professional expertise and autonomy that allows them to prescribe medication and to be held accountable for their prescribing.

Proper Pharmaceutical Care cannot be delivered in an ad hoc, over the counter style service. It relies upon a detailed and uninterrupted interaction with the patient in a consultation room, in similar way to a GP consultation.

- 3.10** In England at least, a range of services purporting to be Pharmaceutical Care, but being something well short of that, have hampered the development of pharmacy south of the border. We are aware that the Scottish Government seeks to pursue a vastly superior approach<sup>12,13</sup>.
- 3.11** Introducing and developing Pharmaceutical Care effectively will require some change to the current skill mix and workforce structure within community pharmacy. The following paragraph summarises the PDA proposals in this regard.

### Community pharmacy workforce

- 3.12** The PDA proposals are predicated on a workforce structure that comprises the following:
- (i) **Registered pharmacy technician** – whose primary responsibility is preparing prescription medicines for dispensing. If pharmacists are to be released from the mechanical aspects of dispensing then a much greater reliance will need to be placed upon the registered pharmacy technician in the dispensary, working under the supervision and personal control of a pharmacist through revised skill mix arrangements.
  - (ii) **Patient facing pharmacist** – whose primary responsibility is to be available to the public at the front counter of the community pharmacy providing both reactive and proactive advice to the public, to include health promotion and a range of low level clinical interventions, e.g. minor ailments. At all times, the ‘patient facing pharmacist’ would also be providing the clinical and professional checks to support the dispensing service. The patient facing pharmacist will be both visible and accessible to the public, providing opportunistic and reactive services directly without the need for an appointment. Freed from the physical act of dispensing, this pharmacist will be ideally placed to focus on tackling medicines waste, adverse drug reactions and the compliance agenda, so delivering improved benefits to patients.

#### References

11. Cipolle RJ, Strand LM, Morley PC. Pharmaceutical care practice: the clinicians guide. 2nd ed. New York: McGraw-Hill; 2004.  
 12. Rogers A. Community pharmacists still don't care. Pharm J 2009;283:413.  
 13. MURs of dubious value. Pharm J 2010;285:322.

- (iii) **Clinic pharmacist** – with responsibility to provide a more comprehensive clinical bridge between the pharmacy, the GP surgery and wider NHS. We propose differing grades of clinic pharmacist (detailed at Section 9) but the focus will be on patients with relatively stable long term conditions who, by definition, have more complex medication regimes. The clinic pharmacist will spend more time with patients than currently the GP or nurse would be able to do in a surgery or home care setting. The service will be on a registered patient and planned care basis, using care pathways supported by local protocols derived from national guidelines. All decisions thus made would directly involve the patient.

### Pharmaceutical Care Services (PCS) Planning

- 3.13** Fundamental to effective provision across Scotland is a clear and authoritative plan of PCS requirements. Legislative provision requiring health boards to produce Pharmaceutical Care Needs Plans (PCNPs) for their respective areas exists but remains to be enacted. **We assume that PCNPs remain a policy intention and recommend the early introduction of PCNPs to take account of possible contract and service provision changes that result from the current review.**
- 3.14** As a consequence of the PDA proposals **we would recommend that the plans identify where, in geographical terms, the services of clinic pharmacists should be made available to the public**, stipulating the number and grade requirements of clinic pharmacists to meet both general PCS and the more specialist needs, e.g. end of life care around care homes and hospice locations, substance misuse in areas of deprivation, etc.

### Delivery

- 3.15** We recommend that service needs are detailed under three main categories over and above the act of 'dispensing', which is delivered under the Acute Medication Service (AMS) of the Scottish CP contract. That is, the act of procuring the stock of required NHS medicines and storing them appropriately for subsequent dispensing on prescription in a regulated manner (e.g. clinically checked, accuracy checked, labelled and provided to the patient with all the requisite advice on self-administration and other associated medicines related issues).

- 3.16** We propose that the procurement and supply process for dispensing forms a separately contracted component within the overall community pharmacy service. Moreover such contracts would be secured at two levels, i.e. supplying medicines (via AMS) directly to the public, and supplying medicines (AMS) to residential and care homes where, due to the nature and needs of residential homes, the specification would be different.
- 3.17** Thereafter, the PCS needs would be categorised and provide for services as follows (in summary):
- (i) **A Minor Ailments Service (MAS).** As now but possibly with revised funding arrangements. This service will be provided by the 'patient facing' pharmacist.
  - (ii) **Public Health Service (PHS).** As now, possibly with revised funding arrangements and cover. This service will be provided by the 'patient facing' pharmacist.
  - (iii) **Chronic Medication Service (CMS).** Currently in its early stages of implementation in Scotland, but for the future we recommend that this service should cover two distinct areas and be provided by appropriately graded clinic pharmacists.
- 3.18** **The first area would be as now, for patients in the community who have relatively stable long term conditions (LTCs).** Within this group would be patients that register (a pre-requirement) with their pharmacy without a GP referral for on-going medicines-related care and support for their LTC condition(s). It would also include LTC patients referred by their GP to the pharmacy of the patient's choice for the full Pharmaceutical Care service. The full PCS would also inherently provide a care plan agreed with the patient and GP, as well as associated on-going prescribing. Under both arrangements the clinic pharmacist would work from a dispensing contractor's premises but would do so under a separate contractual arrangement with one or more health boards.
- 3.19** **The second area would be patients in residential care homes. This service would provide individual care home residents with a Pharmaceutical Care service as outlined in 3.18.** However, as described in 3.16, due to the differing needs and arrangements in residential care homes, the service specification would be different in so far as it would require a service that was integrated with the residential care home management.

**3.20** There are two contract models here but in either event the service would be provided through a contract between the clinic pharmacist(s) and the local health board. Under the first model it would be for the individual patient, their carer or family (or the GP or another healthcare practitioner) to select their clinic pharmacist from a list of health board approved contractors. And under the second model, it would be for the residential care home to select the clinic pharmacist from a list of health board approved contractors. The service would then be provided by that clinic pharmacist under a health board contract to all patients residing in the care home that needed such a service. Such an arrangement would mean that the supply service to that residential care home could remain flexible and be provided by a community pharmacy contractor, or even a series of community pharmacy contractors over time (as long as they held a contract with the health board to supply services to residential care homes), whilst the continuity of Pharmaceutical Care at patient level would be separately contracted and provided by the clinic pharmacist.

## > Section 4 – Utilising released and new healthcare service capacity

This section expands on how and where the released and new service capacity outlined in Section 3 should be utilised. It describes how that capacity should be used to improve the care regimes for patients with long term conditions and increase the focus on preventing unnecessary hospital admissions through a combination of close monitoring of 'at risk' patients, adopting a 'virtual ward' approach, and reducing the incidence of adverse drug reactions and medicines wastage.

### Encourage collaborative management of long term conditions

- 4.1** Patients with LTCs represent the majority of those cared for by the NHS – both in primary and secondary care<sup>14</sup>. They account for up to 80 per cent of primary care consultations, and two thirds of emergency hospital admissions. People with LTCs are also high users of pharmacy services, but it is GPs that currently undertake the majority of their routine care. This care takes up considerable amounts of surgery time and patients can wait several days to see their GP for a routine appointment. Feedback from our meetings with patients indicates that when people with LTCs get to see their GP, they often feel they have insufficient time to properly discuss their needs. Paradoxically, those patients requiring immediate access to their GP due to an acute presentation often feel that they cannot get an urgent appointment, and even if they do attend the surgery, often there appears to be a log jam of patients waiting to see the GP.
- 4.2** Section 3 outlined the establishment of an appointment-led service by a clinic pharmacist whose responsibility would be to provide a more comprehensive bridge between the pharmacy, GP surgery and wider NHS for patients with recognised LTCs or continuing care needs. **By building up a list of registered patients and developing CMS through Pharmaceutical Care by either GP referral or direct patient registration, the clinic pharmacist will be responsible for developing clinical relationships and establishing care plans co-designed with individual patients and their carers that are subject to regular review.** In this way the patient is guaranteed continuity of care, a focus upon Pharmaceutical Care, and a significantly improved patient journey.
- 4.3** This transfer of routine LTC patients away from GP surgeries will build primary care capacity, enabling GP practice based teams to devote more time to delivering continuity of care for the remainder of their patients – especially those with the most complex and acute care needs and thereby at higher risk of hospital admission.
- 4.4** It is recognised that, through CMS in Scotland, focusing attention and care on people with LTCs in both community pharmacy and general practice settings is no longer conceptual. However, adoption and implementation of CMS to date has been limited. We do not attempt to speculate on the reasons for this here but **we recommend that the way to take the overall objective forward is through a combination of new contractual structures that seek to make individual pharmacists (as opposed to large corporate organisations) both responsible and accountable for the patients Pharmaceutical Care needs.** Individual professional accountability is the very essence of Pharmaceutical Care. **The new contractual arrangements must additionally promote more integrated and collaborative working between GPs, pharmacists, and other members of the primary healthcare team.**
- Focus on reducing unnecessary hospital admissions**
- 4.5** The 2010 Audit Scotland Report on Emergency Services<sup>15</sup> stated that in 2008/09 the equivalent of 1.4 million (now 1.56m) people in Scotland attended an emergency department at a cost of £148 million (now £156m). It also stated that around 17 per cent of those patients were aged over 65. By 2031, the number of people aged between 60 and 74 is projected to rise by 40 per cent, and by 61 per cent for the 75 and over group. Given these rates of

#### References

14. Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health and Long-Term Conditions. The Bow Group, 2010.  
15. Emergency departments. Audit Scotland, 2010.

attendance and growth for the older population, if the current system is not made more efficient then the future impact on emergency departments will be significant.

### Incentives to reduce hospital admissions

- 4.6** A supportive step in tackling this situation has already been taken with the April 2012 introduction of new QOF indicators for GPs aimed at reducing avoidable A&E attendances – with a specific focus on older patients with co-morbidities at high risk of admission. The indicators are planned to cover 2012-13 and should result in the production of service improvement plans, the delivery of which should be greatly assisted by the additional capacity proposals outlined in this submission. However, **we recommend that the delivery of these plans should be further encouraged by being subject to continuing QOF or healthcare quality targets.** We highlight below a number of areas where this could be beneficial in both cost and health outcome terms. **In particular, we believe that GPs should be incentivised via the QOF system to refer patients with LTCs to suitably qualified clinic pharmacists.**

### Avoiding hospital admissions through greater access to urgent care

- 4.7** **Surgeries with enhanced capacity could become more orientated to handling acute presentations and so prevent patients from presenting to A&E departments unnecessarily.** This is one of the key themes developed by the BMA in Scotland as part of 'The Way Ahead' initiative<sup>16</sup>. It's acknowledged that this would require a whole system re-orientation but **we recommend the initiative as whole is incentivised through new and improved contractual arrangements for GPs, supported by a strategy and funding to provide for the establishment or upgrading of suitable premises. We would also recommend that the enhanced access to the GPs' urgent care service is subject to a high profile public information campaign, indeed this would be a necessity.**

### Preventing hospital admissions through smarter care of patients

#### a) The Virtual Ward approach

- 4.8** A classic demonstration of how using the skills of the existing team to much better effect would be to **use enhanced General Practice capacity in a proactive way to operate a virtual ward approach.** In essence this is a way of using IT to locate patients with the most complex medical and social needs and focusing support in the community upon them. It employs the systems and skill mix of a hospital ward without the physical building and provides preventative care for people in their own homes.
- 4.9** Using risk stratification, patients are identified by their likelihood to require admission into hospital within the next year – by practice or a group of practices – or by the number of long term conditions they have. Medical input to the virtual ward is provided by the GP. The virtual ward team meets weekly with the GP practice to discuss patients on the case load. The team is also able to book surgery appointments for the patient to see their usual GP. The day-to-day clinical work of the ward is usually led by a senior nurse who may be an assertive case manager or a community matron. Other staff include: a social worker, health visitor, community nurses and other allied health professionals. **We recommend that a clinic pharmacist is actively involved in the virtual ward team.**
- 4.10** The provision of Pharmaceutical Care in a virtual ward style arrangement is an extremely important ingredient in the reduction of unnecessary hospital admissions. Evidence of this has been demonstrated in the work being undertaken in the Lothian Health area as part of a SG Change Fund initiative. This is piloting poly-pharmacy reviews involving community, hospital and managed sector pharmacists for selected patients' medication. Initial results from this virtual ward initiative suggest it is achieving a reduction in hospital re-admissions of around 40 per cent.

#### References

16. General Practice in Scotland: The Way Ahead – Final Report. BMA Scotland, 2010.

**4.11** The virtual ward approach has already been adopted by a small number of health boards in Scotland and we would recommend that steps be taken to further encourage the adoption of this initiative. As well as the possible lack of primary care capacity, this low adoption may come from the absence of a nationally developed combined predictive tool/model to underpin risk stratification. **We therefore recommend that the national development of a combined predictive tool/model to underpin risk stratification is made part of an initiative to promote virtual ward practice in Scotland.**

b) By referring patients with LTCs to clinic pharmacists

**4.12** At the core of these proposals lies the recommendation that GPs are better able to utilise their skills by passing their routine operations to other suitably qualified members of the primary healthcare team. **Once a patient has been diagnosed with a LTC and once that condition is stabilised, it would be of benefit for that patient to be referred by the GP to a clinic pharmacist who could properly meet the Pharmaceutical Care needs of that patient.**

### Reducing adverse drug reactions through Pharmaceutical Care

**4.13** As many research articles report, medicines management has the potential to result in better and more cost effective prescribing in primary care, as well as helping patients to manage medications better<sup>17,18,19</sup>. Around 7 per cent of all hospital admissions<sup>20</sup> have been attributed to, or associated with, adverse drug reactions (ADRs) – with up to two thirds of these being preventable. Interactions have been found to be responsible for one in six ADRs implicated in these admissions. Between 11-30 per cent of hospital admissions result from patients not using their medicines as recommended by the prescriber<sup>21,22</sup>.

**4.14** The National Patient Safety Agency estimates that avoidable hospital admissions due to ADRs cost the NHS in England around £359 million per year<sup>23</sup> – some £36m in Scotland on a proportional basis. These admissions are caused by patients being harmed by their medicines, rather than them not taking them in the intended way. Even a relatively small reduction in this total would result in substantial cost savings and improvements in patient well-being.

**4.15** Adverse reactions are particularly common among vulnerable groups, such as the elderly and frail and older patients in residential and care homes. This group will become much larger in the foreseeable future (paragraph 2.1), so we therefore recommend that a quality focus on this important group is made a priority.

**4.16** **Clinic pharmacist led Pharmaceutical Care interventions will provide educational information and medicines use optimisation services** to this high user group in the community and have the potential to reduce prescribing and monitoring errors among other high-risk patients. This would improve compliance and reduce the frequency of adverse drug reactions, ensuring that patients feel more confident and able to understand and adhere to their medication regimes, thus improving outcomes. **Such interventions would aim to support patients in enabling them to take greater control of their medicines regimes.**

### Reducing medicines wastage through Pharmaceutical Care

**4.17** Whilst reducing medicines wastage is not in itself a directly contributable factor in reducing hospital admissions, it should result from an increased focus under PCS on inappropriate medicine regimes and the early intervention on same. It is therefore apposite to consider the issue in this Section.

#### References

17. Doman T et al. An in depth investigation into causes of prescribing errors by foundation trainees in relation to their medical education – EQUIP study. General Medical Council, 2009.
18. Avery A et al. Pharmacist-led information technology-enabled intervention for reducing medication errors: multi-centre cluster randomised controlled trial and cost-effectiveness analysis (PINCER Trial). *Lancet* 2012;379(9823):1310-9.
19. Avery A et al. Investigating the prevalence and causes of prescribing errors in general practice: The PRACtCe study. General Medical Council, 2012.
20. Pirmohamed M et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients. *Br Med J* 2004;329:15-9.
21. Col N, Fanale JE, Kronholm P. The role of medication non-compliance and adverse drug reactions in hospitalisations of the elderly. *Arch Intern Med* 1990;150:841-5.
22. Wasserefallen JB, Livio F, Buclin T et al. Rate, type and cost of adverse drug reactions in emergency department admissions. *Eur J Intern Med* 2001;12:442-7.
23. Safety in doses: medication safety incidents in the NHS (Patient Safety Observatory report). National Patient Safety Agency, 2007.

- 4.18** Currently there is little by way of national data for Scotland on the costs of medicines wastage or the consequences of ADRs. However, the 2010 York University report 'Evaluation of the Scale, Causes and Costs of Waste Medicines'<sup>24</sup> has been largely accepted as authoritative and equally applicable for Scotland. Thus, a 10 per cent of cost factor is a reasonable estimate on which to consider the Scottish implications, although this is lower than figures quoted in BMA and RCN reports that equate to 15 and 17 per cent respectively.
- 4.19** The York report indicates that the gross annual cost of NHS primary and community care prescription medicines wastage in England is currently in the order of £300 million. This sum represents approximately £1 in every £25 spent on primary care and community pharmaceutical and allied products use, and 0.3 per cent of total NHS outlays. It includes an estimated £90 million worth of unused prescription medicines that are retained in individuals' homes at any one time, £110 million returned to community pharmacies over the course of a year, and £50 million worth of NHS supplied medicines that are disposed of unused by care homes.
- 4.20** The York Report states that net savings from investing further resources in reducing waste per se are likely to be less than 50 per cent of the £300 million figure – in part because a root cause is illness progression and associated treatment changes. This again points to the benefit of the proposed clinic pharmacist role to undertake more focussed regular Pharmaceutical Care reviews with early change interventions where necessary.
- 4.21** However, The York Report also states that over twice the level of identified avoidable waste costs, i.e. up to £500 million in England, could be generated in just five therapeutic areas (**asthma, diabetes, raised blood pressure, vascular disease and care of people with schizophrenia**) if medicines were used in an optimal manner.
- 4.22** **In short, the emphasis should be on health outcomes rather than waste reduction alone. We would therefore recommend that the future QOF indicators proposed at paragraph 4.6, and outcome measures in both the GPs' and community pharmacy contracts, should focus initially on these therapeutic areas.**
- 4.23** At the time of drafting this submission we understand that the intention is to extend CMS to provide early engagement with patients on newly prescribed medicines to increase compliance and reduce waste; and to support patients on specific forms of medication where greater support might be appropriate. This helpfully sets a course that will begin to address some of the issues discussed above.

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#### References

24. Trueman P et al. Evaluation of the Scale, Causes and Costs of Waste Medicines. University of York and The School of Pharmacy, 2010.

## > Section 5 – Contracting for Pharmaceutical Care services

This section argues the case for new contractual arrangements in primary care, based on the need for clear professional autonomy and the removal of conflicts between a contractor's professional and commercial interests. It calls for separate contracts for dispensing/supply and Pharmaceutical Care services, sets out the principles to underpin the approach and provides a number of contract models for delivering Pharmaceutical Care services.

### Professional autonomy – the rationale for new contractual arrangements in primary care

- 5.1** Professional autonomy is essential if Pharmaceutical Care is to be delivered effectively. The pharmacist must be answerable to the patient and other members of the healthcare team – this cannot occur if the commercial demands of an employer primarily involved in sales and supplies are allowed to over-ride the individual practitioner's professional judgement. The NHS will not obtain maximum benefit unless the pharmacist can act in the patient's best interest rather than that of their employer – pharmacists need to be able to act with appropriate levels of professional autonomy.
- 5.2** Today, fewer than 10 per cent of pharmacists own pharmacies, and most of the profession is made up of employees or self-employed locums<sup>25</sup>. The vast majority of community pharmacies are owned by large corporations, supermarkets, multiple high street chains and wholesalers, and even venture capital companies<sup>26</sup>. These businesses are understandably driven by the need to deliver a significant return on investment for their shareholders and financiers. In recent years in particular, alongside the corporatisation of community pharmacy the pharmacist's professional autonomy has been eroded to the extent that employees and locums are under intense pressure to comply with employers' commercial imperatives<sup>27</sup>.
- 5.3** As a trade union and defence association, the PDA sees many examples where the erosion of this autonomy occurs and where it is treated as a burdensome expense by some employers. Often this erosion detrimentally affects patients. In 2011 alone PDA dealt with more than 4,000 incidents in which members were defended in a wide range of

situations, but over half were episodes of employee/ employer conflict. Often these disputes occurred because the decisions and actions of pharmacists are primarily being driven by the professional interest and the interest of the patient, whilst those of the employer are being driven by the commercial interest and the interests of the employer/ shareholder.

- 5.4** In a significant number of cases, conflicts between employers and pharmacist employees occur because pharmacists prefer to put patients' interests ahead of the financial interests of their employers.

### Professional autonomy and the law: the European Court

- 5.5** The principle that the dilution of professional autonomy in community pharmacy is detrimental to the public interest has recently been confirmed in the European Court of Justice, when it ruled on an issue of whether the ownership of pharmacies should be restricted solely to pharmacists.
- 5.6** In the case of C-369/88 Delattre [1991] ECR 1-1487, paragraph 54, the European Court of Justice affirmed that central to its concerns were situations relating to medicines where employers could not be prevented from exerting influence over their employed pharmacists.

### The Court ruled that:

**“In particular, a member state may take the view that there is a risk that legislative rules protecting the professional independence of pharmacists will not be observed or will be circumvented in practice.”**

#### References

25. Seston E, Hassell K. Pharmacy Workforce Census 2008: Main findings. RPSGB, 2009.  
 26. Register of Pharmacy Premises. General Pharmaceutical Council, 2012.  
 27. Harding G, Taylor K. The McDonaldisation of pharmacy. Pharm J 2000;265:602.

We do not seek in this submission to revolutionise the ownership profile of community pharmacies in the UK. However, we firmly believe that the principles put by the Court which deal with the supply of medicines to the public are even more pertinent to patient interest when applied to the provision of Pharmaceutical Care services. We see many examples of situations where the independence of pharmacists is systematically circumvented in practice.

**5.7** If new Pharmaceutical Care services are to develop then, in light of our experience with employee/ employer conflicts to date, **we recommend that contracts for Pharmaceutical Care services should rest either with individuals who are pharmacists – some of whom may also be the owners of pharmacies – or with vehicles that are independent of the retailing culture that currently prevails within community pharmacy.** And that those **contracts should, through commissioning principles, commit contractors to high standards of professional healthcare delivery and be supportive of professional independence of pharmacists.**

**5.8** The PDA believes there is a need to fundamentally revisit and design new commissioning strategies and contractual arrangements that manage these conflicts in a way which is beneficial to patients. We therefore **recommend separating the contract for supply (and those services directly associated with the supply) from the contract for the delivery of Pharmaceutical Care services.** We believe that new contractual mechanisms which place the key focus upon the Pharmaceutical Care needs of the patient will significantly improve clinical care and the overall patient journey.

### PDA contracting proposals

**5.9** Although the current pharmacy contract has been effective at delivering a low cost, volume based supply service, we believe that a volume based approach will not drive quality improvement and a person centred approach through Pharmaceutical Care.

**5.10** The current Review of Pharmaceutical Care in Scotland provides the opportunity to look afresh at the contractual arrangements needed in primary care and consider how best to enable pharmacists to deliver a high quality clinical service to patients.

**5.11** As argued above, the PDA considers it highly appropriate to separate the contracts for dispensing and the associated supply service from the much more clinically orientated Pharmaceutical Care service. Our proposals would create not only professional autonomy but also commissioning flexibility to meet the needs of local populations in line with Scottish Government policy as set out in its Healthcare Quality Strategy<sup>28</sup>. At their heart lies the flexibility to commission PCS from named individuals without the requirement to own a pharmacy premises.

**5.12** While it will be important for any such new contractual arrangements to be co-designed by a wide range of stakeholders, **we recommend the following principles are necessary to underpin the proposed contractual approach:**

- Pharmacists providing Pharmaceutical Care to patients must be able to do so with professional autonomy so that professional practice is not compromised by commercial retailing/ wholesaling considerations.
- Dispensing and Pharmaceutical Care services should be commissioned separately and provided in parallel to each other.
- Community pharmacies are a vital part of local communities so any new contracting arrangements must stabilise the existing asset this network represents.
- Individuals or organisations that have invested in the provision of services must enjoy a fair return on that investment and risk, i.e. on the financial investment and risk for operating a community pharmacy, or an intellectual investment and professional risk for operating Pharmaceutical Care services.
- Individual pharmacists should be named in Pharmaceutical Care services contracts and be accountable for quality and outcomes against a nationally agreed NHS Outcomes Framework
- Patient registration should be considered in a way that preserves patient choice AND facilitates continuity of Pharmaceutical Care and accountability for outcomes – particularly for those on the more complex medicines regimes associated with LTCs.

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#### References

28. The Healthcare Quality Strategy for NHS Scotland. The Scottish Government, 2010.

- The model should be simple and flexible enough to meet the needs of patients, commissioners, a range of service providers and professionals.
  - The pharmacist delivering Pharmaceutical Care services will mainly be in one-to-one consultation with patients – usually in the consultation room. Consequently, this pharmacist should not be the Responsible Pharmacist charged with the important task of securing the safe and effective running of the pharmacy, as it will be important to ensure that patients walking into the pharmacy without an appointment to receive a dispensing service and others seeking advice can speak to the available Responsible Pharmacist.
  - Outcomes should link to remuneration. A Quality and Outcomes Framework (QOF), similar to that in the GMS contract should be developed for clinic pharmacists.

**5.13** Within these principles we have developed several broad options. They are not mutually exclusive and are essentially a starting point for discussions with all relevant stakeholders.

#### **(a) Independent clinic pharmacist**

A pharmacist is contracted by the NHS to provide Pharmaceutical Care services to a population of patients registered with a pharmacy. The pharmacy owner holds the dispensing contract and the clinic pharmacist holds the health board contract for providing the Pharmaceutical Care service that is operated from the pharmacy. The clinic service would be commissioned on a sessional basis (e.g. in half day blocks) and would broadly be informed by the number of patient registrations. The clinic pharmacist is accountable for achieving measurable outcomes for registered patients. Under the clinic pharmacist's contract with the health board, a fee would be paid to the clinic pharmacist, part of which may be paid by them to the owner of the pharmacy for use of the consultation room and facilities. Contracting arrangements would define and protect the independence of the clinic pharmacist from any financial interests associated with dispensing /sale or supply of medicines or wholesaling.

#### **(b) Group practice**

A group of suitably qualified pharmacists – any one of whom could provide services on a sessional basis – join together to form a group practice. The contract is held with the practice and the practice as a whole is accountable for achieving outcomes and maintaining standards. Similar financial arrangements and operational independence would operate as in (a) above.

#### **(c) Pharmaceutical Care services provided by an existing pharmacy contractor**

The pharmacist pharmacy contractor owns the premises and holds both the dispensing contract and the Pharmaceutical Care services contract. The contractor is accountable via two contractual routes, which have different outcome measures. Governance, monitoring and review ensure that Pharmaceutical Care activities are high quality and operate free of constraints from financial interests in dispensing or other forms of medicines supply. That principle could be reinforced by professional ethics. This option may be particularly suitable for suitably qualified pharmacist independents in quieter pharmacies, who wish to specialise and both dispense and provide Pharmaceutical Care services. This approach is one that would be supported by the European Court of Justice's ruling referred to earlier in this submission.

#### **(d) Franchise model**

This would see a corporate pharmacy provider harnessing the asset of its brand and developing a Pharmaceutical Care service offer that individual suitably qualified clinic pharmacists could buy into. It could include advertising and facilities as well as being able to provide a registered patient population. This model has parallels with the model that operates in some supermarket pharmacies and other supermarket franchise providers and is already seen in other areas of healthcare provision e.g. dentistry and optical services.

#### **(e) Specialist provider**

A company probably established by a Pharmaceutical Care specialist holds the contract for the delivery of Pharmaceutical Care and is responsible for quality and outcomes. The company employs suitably qualified pharmacists to deliver services. It also provides the clinical governance framework and is accountable for the service specification. It is responsible for recruiting and training pharmacists and for monitoring and maintaining their performance.

**(f) Social Enterprise**

As well as commercial business models, there are opportunities for pharmacy businesses to expand and develop as social enterprises, employing a range of business models from co-operatives through to community interest companies. Many of these models already exist within the sector, with a co-operative provider being one of the largest pharmacy businesses currently.

**5.14** We believe that the separation of contracts for Pharmaceutical Care and dispensing services will offer many benefits:

- It will stimulate the provider market
- It will deliver a wider range of more flexible contracting options when commissioners identify communities with unmet Pharmaceutical Care needs in their Pharmaceutical Care Needs Plans – as outlined in Section 3
- It will offer pharmacists more career options in community pharmacy
- And it will reassure health care professionals, including GPs, that clinic pharmacists operating from the community pharmacy can do so freed from the direct and relentless pressures of retailing activity.

## > Section 6 – Other contracting issues

This section expands on the discussion at Section 5 by detailing a number of specific issues that should be addressed through health boards' overall contract and service planning arrangements, namely:

- The need to make better use of, and to further develop, the effectiveness of the existing pharmacy premises network
- To that end to have greater cross-collaboration between pharmacies and collaboration with dispensing doctors
- To improve service availability and access in remote and rural areas
- To have dedicated PCS for people in residential care homes
- For clinic pharmacists to be accredited in the delivery of specialist services.
- Substance misuse services
- Consultant services in the community
- Physiotherapy and other rehabilitation services
- Podiatry.

To a limited degree an approach in this direction has already been taken in Scotland through a pilot to test pharmacy walk-in services, i.e. the 'Pharmore' initiative, more details on which are at Section 8. (8.5)

### The creation of a further modernised pharmacy network

- 6.1** Across the UK an estimated 1.6 million people visit a pharmacy each day. Of these, 1.2 million do so for health-related reasons. This is twice the number of people who see a GP. Pharmacies are open at weekends, evenings and bank holidays. This makes pharmacy a highly accessible primary care service and currently, an underutilised primary care asset.
- 6.2** Currently most pharmacies in Scotland have some form of consultation room, which suggests that community pharmacies are already in a position to operate clinics for patients with LTCs without the need to invest in substantial capital programmes. Nevertheless, **we recommend the further development of consultation rooms in community pharmacies to facilitate the development of community pharmacies as a much more comprehensive community resource, hosting a wide range of healthcare services.** This would considerably bolster the current NHS facilities infrastructure. The modern pharmacy could, for example, host:
- GP 'branch' clinics
  - Practice nurse clinics
  - Community nursing services
  - Counselling services, e.g. cognitive behavioural therapy
  - Health trainers

### Collaboration between pharmacies

- 6.3** The primary model within these PDA proposals is that clinic pharmacists work largely out of existing community pharmacies but under separate contractual terms. Not every pharmacy will require or be physically capable of hosting the clinic pharmacist's services. Therefore there needs to be, and **we recommend collaboration between the two parties in terms of shared access to and between pharmacy premises.**
- 6.4** A second element of how cooperation may provide Pharmaceutical Care is where two or more pharmacies combine their practice into one larger central location. A pre-condition of such an arrangement would have to be that it would not harm the existing pharmacy network or the availability of pharmacy services to the community. Consequently a small town that has three pharmacies all located in the high street may provide just such an opportunity. Consolidation would allow the three pharmacists hitherto employed in the three pharmacies to work in a more collaborative and clinical fashion to deliver Pharmaceutical Care, whilst still guaranteeing a high quality supply service.
- 6.5** In both cases the health boards' planning process (Section 3 paragraphs 3.14 and 3.15) should address the need for individual pharmacies to share premises/facilities for the delivery of clinical PCS in defined localities. **The PCPN plan should also provide for one or more clinic pharmacists to serve a wider geographical area by working across a number of pharmacies and even other locations such as residential homes on different days.**

### Collaboration between community pharmacists and dispensing doctors in remote and rural areas

**6.6** Once the supply function is contracted separately to a Pharmaceutical Care service, it becomes possible to complement the dispensing service currently provided by dispensing doctors in the more remote areas by a Pharmaceutical Care service provided by a clinic pharmacist. This would be done in exactly the same way as the pharmacist would operate from a community pharmacy or other suitable location. As described before, the health board would contract one or more clinic pharmacists to provide Pharmaceutical Care services to patients that otherwise would have no access to that level of healthcare and they would provide those services directly to patients in the dispensing doctors' practices in the more remote and rural areas. Such an arrangement would provide all of the benefits of collaboration, integration, reduced professional isolation and most importantly of all a significant improvement in patient experience.

### Residential care homes

**6.9** The PDA proposal includes the introduction, through health board contracts, of clinic pharmacist services to care homes, separate to the supply contracts for medicines and appliances. In practical terms this would provide for a full Pharmaceutical Care service for those residents with long term conditions. It will require close co-ordination and communication between the homes' nursing/care staff and the individual residents' GPs.

**6.10** These arrangements would allow the residential home to develop a relationship for the supply of medicines with a pharmacy of their choice; for the residents of the home and their families/carers to develop a clinical relationship with their clinic pharmacist; and for the clinic pharmacist to develop a clinical and care relationship role with care home management teams for the benefit of the wider residential home service.

**6.11** As indicated above, the general supply and storage review/maintenance of prescribed and OTC etc. medicines to residential care homes would be under separate contractual arrangements. These could be with one or more local community pharmacies.

### Specialist Pharmaceutical Care Services

**6.12** The PDA proposals at Section 9 call for a structured career framework based on four grades of pharmacist, namely – practitioner, advanced practitioner, specialist and consultant. The intention is that **within this graded structure pharmacists will be accredited to practice in a range of specialist programmes, e.g. end of life care, palliative care, substance misuse, diabetes, etc.**

**6.13 The health boards' PCNPs plans should identify where such specialist services are required.** Having done so, they would contract with the clinic pharmacists who have the recognised specialty skills or knowledge in those areas. In such a way, one specialist clinic pharmacist could deliver continuity of care to a large number of 'like patients' across a distinct geographical area, provided in different locations on different days depending upon need.

## > Section 7 – Information sharing and IT

This section endorses RPS(S) and RCGP(S) statements regarding the need for GP/pharmacist collaboration in sharing patient data and for the further IT development of data access and transfer facilities. It also provides a number of IT develop areas that are considered worthy of priority for pharmacy and wider NHS use.

### Collaboration and development priorities

**7.1 A key need for both the patient facing and clinic pharmacist is formal access to patient records that lie outside the pharmacy,** e.g. in GP surgeries, the out of hours service, laboratory results, patient discharge letters - all ideally through computer links into the pharmacy.

**7.2** One of the building blocks for change in the Joint statement by RPS(S) and RCGP(S)<sup>29</sup> – commented on at Section 3 – is the need for increased sharing of patient information facilitated by improving inter-professional IT links with clear safeguards for consent and confidentiality. We have already endorsed that objective and would also fully endorse the following, which is part of the statement:

**“21. Making CMS work will require improvements in the sharing of information between the pharmacist and general practice.**

We welcome the recent Scottish Government eHealth strategy for 2011-2017 that aims to create an Electronic Medicines Record (EMR) and welcome the commitment to making that available to community pharmacists by 2014.

**22. There should be an integrated patient care record available for both primary and secondary care to allow up to date patient information to be accessible by the appropriate healthcare provider.** This should include medicines prescribed by GPs and dispensed by pharmacists. A mechanism should also be identified to record clinically significant over-the-counter sales, Minor Ailments Service (eMAS) consultations and other public health interventions.”

**7.3** We are aware that the Scottish Government’s 2011 ‘eHealth Strategy 2011-2017’<sup>30</sup> is substantial and includes a range of aims and initiatives that, to varying degrees, will introduce further patient data access and transmission appropriate to community pharmacy, and its necessary linkage to and between other care points. It is a large agenda and we have to be realistic about the priority that will be attached to community pharmacy in the full scheme of things. However, there are a number of information/IT developments that we would flag as meriting rank in any priority order that we could influence:

- Patient records to include details of patient’s carers and their levels of support and decision making abilities.
- The remote capture and relay of physiological measurements/data from patients’ homes for clinical review by the pharmacist – to enable early intervention to adjust medicine regimes where necessary, or to refer on to another healthcare professionals.
- Video consultation facilities – particularly in remote and rural areas – for routine appointments between clinic pharmacists and their registered LTC patients. Would also allow pharmacist/GP dialogue to support diagnosis, medicine decisions and raising prescriptions.
- Robotic dispensing – again particularly beneficial for enabling key healthcare staff to focus their unique skills upon patient care and become less involved in the mechanics of dispensing.

#### References

29. Breaking down the barriers – how pharmacists and GPs can work together to improve patient care. RCGP Scotland and RPS Scotland Joint Statement, 2012.  
30. eHealth Strategy 2011-2017. The Scottish Government, 2011.

## > Section 8 – The patient focus

This section summarises the patient benefits that would accrue from the introduction of clinic and patient facing pharmacist services and consequential increase in GP capacity. It supports the complementary development of 'pharmacy walk-in services' and outlines the patient safety needs in terms of self-care and the community pharmacy environment.

### Patient benefits

- 8.1** Encouraging patients to take ownership of their treatment, especially those with LTCs, lies at the very heart of the PDA proposals. Embedded within the proposals is a focus upon shared decision making that involves patients and carers at all times. Allowing LTC patients to co-produce their care plans with their care team will generate a sense of self control and personal responsibility for their health, which in turn will deliver better outcomes.
- 8.2** Focus group work undertaken by the PDA has indicated that many patients feel unable to spend adequate amounts of time with their GP due to the burden of surgery work. As a consequence they often leave the surgery with a complex medicinal regime about which they have many unanswered questions. As evidenced earlier in this submission, this has been shown to result in poor compliance and added waste. The service we describe would allow patients to spend much more time discussing their medicines with an expert, and they would become much more proximate to the pharmacist. Furthermore, because the service would be provided on a managed and patient registered basis, it would provide the continuity of care that currently evades much of the current community pharmacy offering – especially that provided by the large corporate multiples.
- 8.3** Further additional and wider benefits of this redistribution of healthcare delivery would primarily flow from the release of significant time for GPs – as proposed at Section 4. If LTC patients were able to receive a quality Pharmaceutical Care service away from the GP surgery, far fewer would need to attend the surgery<sup>31</sup>. This would lead to improved capacity and responsiveness of GPs and their staff, enabling them to deal with the more complex and acute presentations. Under this scenario, it becomes possible to encourage many more patients to present at the GP surgery for urgent treatment, rather than to attend the local A&E department with conditions

that could easily be treated in the less costly primary care setting. This would be a far more attractive proposition for patients, and would be seen as a huge improvement of their NHS care provision.

### Pharmacy walk-in services

- 8.4** The above focuses predominately on the benefits of introducing a clinic pharmacist service. However, the public in general would benefit from the proposed expansion of the 'patient facing' service that provides opportunistic and reactive healthcare advice directly to people coming into a pharmacy – without the need for an appointment.
- 8.5** We are aware of the test work currently being undertaken in some seven community pharmacies across Scotland under the 'Pharmore' initiative. These pharmacies offer a selection of walk-in services ranging from nurse-led minor illness and injury treatment, sexual health advice, and simple diagnostic healthcare checks and tests. They also offer more convenient opening times, including extended evening and weekend opening hours, and in most cases operate without the need for an appointment. This welcomed approach is entirely consistent with the PDA proposals which, if adopted, would increase its adoption across a much wider area of Scotland.

### Patient safety

- 8.6** With an increased use of community pharmacies for both 'off the street', and appointment-led consultations, generated by the patient facing and clinic pharmacists, there is a need to ensure that people are seen – and are encouraged to manage their own self-care – in an appropriate and safe environment.

#### References

31. Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health and Long-Term Conditions. The Bow Group, 2010.

- 8.7** In the more specialised ‘clinic pharmacist’ scenario the focus would be on planned care using care pathways supported by local protocols, derived from jointly agreed national guidelines, that include risk management measures to reduce the risk of avoidable injury or harm.

### **Confidentiality**

- 8.8** Confidentiality will be an important issue; it will require appropriate privacy and secure storage arrangements especially in so far as it relates to the use of patient information.

## > Section 9 – Workforce, education and training

This section outlines the current workforce position and the need to introduce a structured career framework within the community pharmacy sector so as to underpin the PDA's proposed Road Map approach. It describes a clinical career pathway and the postgraduate support and development requirements, and the need for these to be on a multidisciplinary footing with other healthcare professionals. Finally it outlines the education and training needs for registered pharmacy technicians and support staff.

### Workforce capacity and capability – the current workforce position

- 9.1** Structural barriers, including regulation, contract design and the burden of dealing with the relentless growth in dispensing workload, have slowed progress. Once these can be overcome, the pace of adoption of new roles will accelerate as pharmacists see that fundamental change is not only possible but that it is a highly desirable outcome.
- 9.2** We believe that there is sufficient capacity and premises within pharmacy to move to the new arrangements on a large scale within a three to five year transition period.
- 9.3** Whilst largely the number of community pharmacies in Scotland is stable, there are a number of dynamics currently in play within the pharmacy workforce situation that are worthy of consideration:
- 9.4** The pharmacy workforce is broadly split into four distinct sectors: community, hospital, primary care (GP surgeries), and 'other' e.g. academia, research, industry, organisational etc. The kind of activity being proposed for the clinic pharmacist is already being undertaken by pharmacists working in hospital and primary care pharmacy settings. It is worthy of note that currently there are in the region of 2,000 prescribing pharmacists annotated on the register of pharmacists held by the GPhC<sup>32</sup> and yet, due to the current paucity of roles for pharmacists requiring such a skill, very few of these are involved in roles where such a prescribing qualification is necessary; and those who are do not have a primary focus on Pharmaceutical Care, ensuring continuity of care and avoidance of hospital admissions<sup>32</sup>.
- 9.5** For a variety of reasons, but at the PDA it is felt largely due to the current dissatisfaction amongst community pharmacy employees with regards to the de-professionalisation of the sector, significant numbers of pharmacists have left their employed position and work as self-employed locums often across a range of sectors (known as portfolio career development). The most recent survey of pharmacists undertaken by the Royal Pharmaceutical Society of Great Britain indicates that 37 per cent of all community pharmacists are locums<sup>33</sup>. Some employers and commissioners view locum and portfolio working as problematic. They feel it has led to a lack of continuity of patient care and it may hamper the consistent delivery of enhanced services that require individual accreditation. This may only be the case however, if the current static 'pharmacy centric' contractual model persists. Should new 'professional centric' contractual arrangements become available, then the flexibility and dynamism offered by such a numerically large group within the profession will prove to be a great strength and it will provide the capacity to grasp the new opportunities that we are proposing.
- 9.6** Whilst in Scotland the number of pharmacy schools has stayed static, the numbers of pharmacy schools in England and Northern Ireland has dramatically increased and three more schools are due to open within the next two years. In 1999 the pharmacy undergraduate population in England was 4,200; in 2009 this was 9,800<sup>34</sup>. These dynamics are already creating pressure on jobs for pharmacists, and this is set to increase in the short term. Such dramatic changes in England will impact upon Scotland. Notably, the graduates of today are all completing a Masters degree, which means that in both quality and quantity the pharmacist population is predisposed to some large scale role enhancement.

#### References

32. Register of Pharmacists. General Pharmaceutical Council, 2012.  
 33. Seston E, Hassell K. Pharmacy Workforce Census 2008: Main findings. RPSGB, 2009  
 34. Royal Pharmaceutical Society of Great Britain (2009) personal communication..

- 9.7** In England there are currently some very significant re-organisations at Primary Care Trust level and this means that a significant number of primary care pharmacists – many of whom are qualified as pharmacist prescribers – are seeking more stability and new roles.
- 9.8** Beyond these important sources, other pharmacists would require a degree of retraining and investment by the NHS and the postgraduate system generally. The rate of progress will be driven primarily by the modernisation of contracting systems and the willingness of the profession to adopt new roles. From numerous surveys and focus groups involving large numbers of pharmacists we have learnt that 20 per cent of our members are willing to engage in these new roles in the short term – subject to guidance and support structures being in place; 45 per cent feel willing to engage, but would need re-training first, and 35 per cent would prefer to remain involved in their more traditional current roles.
- 9.9** There are currently around 5,000 pharmacists involved in primary care in the UK, of which more than half are in PDA membership<sup>35</sup>. In Scotland there are nearly 250 primary care pharmacist members of the PDA. Some work full-time or on an exclusive basis, but for many this is part of a portfolio career that involves different jobs and responsibilities that may straddle several sectors of pharmacy.

### Re-designing pharmacy training

- 9.10** We recommend that consideration is given to a **new five year pharmacy training programme that would include a much more integrated work placement element that blends educational teaching and practical patient-facing clinical experience**<sup>35</sup>. **Additionally, we advocate undergraduate training that is more integrated with that provided to future doctors and nurses.** The aim would be to produce pharmacists that are able to take on significantly more complex clinical roles as soon as they qualify. Added to this would be the creation of a structured career framework in the community sector as described below.

### A clinical career in community pharmacy

- 9.11 PDA members tell us that a structured career pathway in community pharmacy would make their professional activities much more rewarding.** The hospital and primary care settings offer transparent, structured career frameworks, linked to financial incentives for skills and competency development through training. This is the case not just for pharmacists, but also for the nursing and the medical profession. Considerable evidence exists to show that the structured career framework acts as a significant incentive for healthcare professionals and this can be linked to beneficial patient outcomes.
- 9.12** No such structured career framework currently exists in the community pharmacy setting – even though it employs around two thirds of all pharmacists<sup>36</sup>. Linking a career structure to the requirements of the NHS in the community setting would be a powerful tool for change underpinning quality and outcomes.
- 9.13** We believe that the proposed clinic pharmacist model could allow career progression by linking clinical competence and qualifications to both service type and grade.
- We recommend a career structure similar to that seen in secondary care, to include pharmacy grades in community pharmacy of:**
- **Practitioner**
  - **Advanced practitioner**
  - **Specialist**
  - **Consultant.**

We would expect a patient facing pharmacist to operate at practitioner and advanced practitioner level, whereas the more demanding clinical work required of the clinic pharmacist would require specialist and consultant level competence. Additionally, since work at this level would involve pharmacist prescribing, an additional layer of regulatory protection would exist since all pharmacist prescribers have a special annotation on the GPhC register. Such a framework would both accommodate additional initiatives such as pharmacists with a special interest and provide a valuable vehicle for focused post graduate education.

#### References

35. Smith A, Darracott R. Modernising Pharmacy Careers Programme: Review of pharmacist undergraduate education and pre-registration training and proposals for reform (Discussion paper). Medical Education England, 2011.
36. Seston E, Hassell K. Pharmacy Workforce Census 2008: Main findings. RPSGB, 2009.

### Postgraduate development

- 9.14** We recommend that once qualified under the proposed new structure, patient facing and clinic pharmacists are given ready access to a central resource centre coupled to on-going support and peer review to both maintain and develop their specialist skills/knowledge for career progression. This should be conducted within a framework of regulatory guidance supported by the use of case studies, and the provision of practical advice on more generic matters such as risk management and professional indemnity etc.
- 9.15** Many of these support mechanisms are already available through existing NHS structures and/or pharmacy organisations. Experience of specialist practice development in the past suggests that many of the new practitioners will also seek to establish their own peer support groups – possibly with the support of the Royal Pharmaceutical Society.

### Multidisciplinary learning

- 9.16** We recommend that the general approach for support and peer review needs to be widened to include other health professionals as the delivery of community healthcare becomes more collaborative and integrated, particularly as new working practices, such as virtual wards, are developed. Review 'groups' would comprise not only community pharmacists and GPs but members of the nursing team and, where clinically appropriate, relevant hospital specialists. In June 2012 the RCGP published a strategy about enhanced GP training, in which it clearly laid out its case for enhancing and extending GP training through multidisciplinary education and co-development between GPs and community pharmacists<sup>37</sup>. The proposals made in this submission provide the ideal operational platform upon which GPs and pharmacists can engage in multidisciplinary learning.

### Pharmacy technicians and support staff

- 9.17** For pharmacists to be able to fully apply their skills and knowledge they will require the routine mechanics of dispensing and other pharmacy functions to be undertaken by support staff. The role and the contribution of pharmacist support staff should be to make pharmacists more available to the public in the pharmacy so that they can deliver their professional skills and judgements for the benefit of the public and any new supervision regime should support that concept.
- 9.18** A consequence of our patient facing and clinic pharmacist proposals is the need for greater reliance on registered technicians, and upon support staff generally. It will be important to ensure such a development is underpinned by appropriate regulation to define supervisory roles and responsibilities and importantly to offer public protection through a regulatory regime<sup>38,39</sup>.

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#### References

37. Preparing the future GP: The case for enhanced GP training. The Royal College of General Practitioners, June 2012.  
 38. Tyas D et al. Are accuracy checking technicians being used as cheap pharmacists? *Pharm J* 2012;288:45-6.  
 39. Tyas D. More accountability. *Pharm J* 2012;288:558.

## > Section 10 – Finance

This section sets out to demonstrate the considerable financial headroom within which the concepts described in the PDA Road Map proposal may operate. This section is not a definitive financial assessment of the exact financial impact, rather it is a financial indicator of how a more integrated delivery of healthcare and the application of Pharmaceutical Care can deliver very considerable improvements in the efficiency of the NHS in Scotland. This analysis is based on the assumption that these proposals will, along with other review submissions, be subject to detailed cost analysis within the Health Department.

- 10.1** In summary, the proposals in this submission demonstrate how a focus upon Pharmaceutical Care will result in:
- A much more appropriate and efficient use of the unique skills possessed by key NHS personnel
  - A meaningful focus upon the medicines use optimisation, medicines waste and adverse drug reaction agenda
  - A transfer of appropriate secondary care activities into the less costly setting of primary care

The following paragraphs expand on the cost and saving implications contained within each on an illustrative basis only.

### Cost of the clinic pharmacist service

- 10.2** This service will revolve around delivering Pharmaceutical Care through optimising the use of medicines and the management of patients who have previously been diagnosed as having a long term condition (LTC), either by their GP or through a secondary care pathway. Our indicative model relies on the fact that:
- The clinic pharmacist service** is taken up on a scale large enough to reduce the numbers of LTC patients currently presenting themselves at GP surgeries so as to increase the capacity of GP surgeries. This **would rely on LTC patients registering with clinic pharmacist services independently and/or also via GP and wider care pathway referrals.**
  - That GPs use the additional capacity to re-orientate their services to make them more responsive to acute presentations** and to further focus their attention upon avoidance and prevention of hospitalisation through, for example a virtual ward approach.

This proposal uses 40 per cent of pharmacies as its indicative (full time equivalent) base line (40 per cent of 1230 = 492 pharmacies) and uses the following cost assumptions for illustrative purposes.

492 x £20,000 (a)\* = £ 9.840m (a)\* Is paid to the clinic pharmacist to cover the cost of a premises fee(s) which they then use to pay to the owner(s) of the pharmacies for the use of the consultation room and operating the appointments service and other premises related activities.

492 x £60,000(b)\* = £29.520m (b)\* Is paid to the clinic pharmacist and would include (for example) salary, PAYE, a contribution towards the costs of on-going training, CPD, clinical governance frameworks and certain operational costs such as membership of the appropriate organisations, professional indemnity and hardware/software support costs.

### A total of £39.360m investment required

- 10.3** Currently data suggests that people with LTCs account for 80 per cent of GP appointments, which on 2010-11 data equates to 18.4m appointments in Scotland (80 per cent of 23m). We expect that a clinic pharmacist could see in the region of 12-20 LTC patients per day, depending on whether this was an initial meeting or a follow-up. Based on our 40 per cent of all pharmacies model, this equates to an approximate number of more than 2million clinic pharmacist patient consultations. *We believe that due to an improvement in continuity of care, these clinic pharmacist consultations will result in an annual reduction of considerably more than 2million GP consultations from this significant LTC cohort of patients.*

## Cost of the patient facing pharmacist service

- 10.4** Scotland already has a Minor Ailments Service (MAS) that provides an advice and free medicine/appliance supply (from a limited formulary) to persons entitled to prescription charge exemption under the pre-April 2011 prescription charge regime. ISD data reports that in April 2011 some 790,500 persons were registered for MAS, with fees to pharmacies in 2010-11 totalling £13.655m. More generally, ISD reports that on average community pharmacists deliver 57,500 consultations each week in Scotland on the treatment of minor ailments.
- 10.5** ISD does not report the number of GP consultations that can be attributed to minor ailments, but data from wider sources<sup>14</sup> suggest that around 20 per cent of GP/practice nurse activity falls into this category. The number of GP/PN consultations in Scotland in 2010-11 was just over 23m (ISD), which points to around 4.6m consultations relating to minor ailments in total, or some 88,500 consultations per week. **Our indicative model assumes that, through a nationally co-ordinated and well promoted media campaign, 40 per cent of these minor ailment consultations could transfer to community pharmacies, i.e. 1.8m, or some 34,600 consultations per week.**
- 10.6** The current remuneration structure leaves many community pharmacists spending most of their time ensconced in the dispensary involved in the mechanics of dispensing. **The management of a much wider transfer of patients with minor ailments from GPs to pharmacists would require some investment in the pharmacy workforce through skill mix to allow registered pharmacy technicians to deal with the mechanics of dispensing, whilst releasing pharmacists to be able to spend most of their time in a much more patient facing role.** The current funding system already has scope and capacity to fund a much wider MAS service and this would require community pharmacists to drive the MAS scheme more pro-actively.
- 10.7** The 2010 Bow Group report 'Delivering Enhanced Pharmacy Services in a Modern NHS ...' quotes the cost of a GP consultation as £32 compared to that at a community pharmacy as £17.75 - a difference of £14.25 per consultation. This indicates that a financial saving can potentially be made with the development of the MAS scheme. However, we believe that the

real significance of transferring patients from GPs to pharmacists is not due to savings on the comparative costs of the minor ailment consultations but due to the beneficial impact of creating additional capacity for GPs, which is then used more effectively to reduce unnecessary A&E admissions and to prevent or avoid hospital admissions.

We believe that within a properly promoted MAS scheme as part of a more integrated primary care service, **a patient facing pharmacist service could reduce the annual number of GP consultations by more than 1.8 million.**

## Savings and resources released

- 10.8** Although the current MAS scheme already has the financial capacity to provide the foundation upon which the patient facing pharmacist could be funded, the clinic pharmacist proposal requires a significant investment cost for wide scale development (£39million). It is important, however, to consider that the consequence of the PDA Road Map proposal is that it ultimately delivers both cash savings (through a reduction in medicines waste, an improvement in concordance and a reduction in drug related hospital admissions) and an increase in GP capacity. This means that services can be provided in the less costly environment of primary care, rather than in the more costly environment of secondary care. All of these benefits are in addition to the delivery of a vastly improved patient journey, to which we have not attributed any figures in this financial analysis.
- 10.9** This section does not set out to provide anything more than an indicative picture of the cost consequences of the PDA proposals. The following section simply illustrates the headroom within these proposals.

## Reduced hospital admissions (general)

- 10.10** ISD data states there were 1.012m inpatient cases in 2010-11 with an average cost of £2739 per case. Research suggests that around 7 per cent of admissions result from ADRs<sup>20, 21</sup>, i.e. some 71,000 cases, leaving 0.941m 'other' admissions.

### An increased GP capacity

**10.11** Our assumption is that a conservative estimate of cost savings resulting from increased GP capacity/ focus on 'at risk' cases would be a 2 per cent reduction in hospital admissions. Additionally we argue that there would be at least a further 1 per cent reduction resulting from the clinic pharmacist interface with LTC patients – a total of 3 per cent reduction. On this basis the resource saving figure would be:

- $0.941\text{m admissions} \times 3 \text{ per cent} = 28,230 \times \text{£}2739$   
(per case) = **£77.322m cost reduction**

NB. This assumption simply attributes savings strictly to reductions in hospital admissions in 'at risk' cases, it does not attribute any financial benefit to the wider 'at risk' patient benefit that is not related to hospital admissions.

### A reduction in ADRs

**10.12** Our assumption for the reduction in ADR admissions is based on there being around 71,000 cases per annum, of which two thirds are preventable, i.e. 47,330; we then further assume that from both the new clinic pharmacist and patient facing pharmacist service there will be an overall 10 per cent reduction in preventable ADRs, i.e.

- $47,330 \times 10 \text{ per cent} = 4,733 \text{ cases at } \text{£}2,739$   
each = **£12,964m cost reduction**

NB. This assumption simply attributes savings to reductions in hospital admissions related to ADRs and does not attribute any financial benefit to preventing ADRs that do not result in hospital admissions.

### Reduced A&E admissions

**10.13** Another consequence of increased GP capacity to focus on at risk patients, and premises upgrades to increase surgeries' capacity to deal with minor injuries and ailments, would be a reduction in A&E attendances. With A&E attendances costing around £156m per annum, a reduction of only 5 per cent in presentations would yield an illustrative saving of around £7.8m per annum. We expect though that GPs would need to be able to fund the capital cost of premises upgrades.

### Reduced medicines wastage

**10.14** Using the York & London University report as a proxy, the estimated net savings from investing further resources to reduce medicines waste is expected to be less than 50 per cent of the projected cost of £30m (Pro-rata figure for Scotland). Therefore an estimate of a net 10 per cent reduction from the amounts ultimately available by the combination of the clinic and patient facing pharmacists could yield a **potential saving of £3m per annum**.

### Improved outcomes

**10.15** The York & London report also estimated the opportunity cost of the health gains foregone because of incorrect or inadequate medicines taking in just five therapeutic contexts to be in excess of £50 million per annum (pro rata figure for Scotland), albeit that realising such gains would – to the extent that effective interventions exist – involve additional costs. Thus, even a 10 per cent 'benefit' from the new clinic and patient facing pharmacist services would yield a **potential saving of £5m**.

### Summary of additional costs vs savings and resources released (rounded)

Strategic area	Additional cost	Resource release/saving
Clinic pharmacist	£39m	
Patient facing pharmacist	Funded through the existing MAS funding route	
Increased GP Capacity		>4million consultations(an additional 18-20% GP capacity increase)
Reduced hospital admissions (general)		£77.322m
Reduced hospital admissions (ADR)		£12.964m
Reduced A&E attendances		£7.8m
Reduced medicines waste		£3m
Improved outcomes		£5m
	<b>£39m</b>	<b>£106m</b>

**10.16** It is recognised that the review of Pharmaceutical Care of patients in the community in Scotland is not primarily driven by a plan to reduce NHS expenditure, rather it is seeking to improve the lives of people living in Scotland through an improved and more efficient delivery of healthcare. It is also trying to establish processes that are sustainable in the future. Nevertheless, it will be necessary for the Scottish Government to be able to make an informed estimate of what it can expect to get in return for an investment in any new process that is established. While it will never be possible to provide precise data in this respect in advance of a launch of the proposed service re-design, the PDA Road Map proposal has been built on a very conservative financial cost vs financial benefits analysis. We have shown that the cost of £39 million invested will produce at least £106million worth of benefit. This shows a return of investment of 2.7 :1. Work done internationally using a variety of approaches to Pharmaceutical Care, demonstrates that we have taken a very conservative approach. The return on investment on Pharmaceutical Care is as high as 12:1<sup>40</sup> and an average of 3:1 to 5:1.<sup>1</sup> Even these estimates are probably lower than actual, because it is difficult to estimate the overall beneficial impact of Pharmaceutical Care upon a patients life.

**10.17** The proposals made in the PDA Road Map proposal operate within a significant financial headroom and additionally potentially deliver many benefits to both the healthcare system generally and the patient journey specifically. As a first step, we recommend that **the PDA's Road Map proposals are subjected to detailed cost analysis within the Health Department.**

#### References

40. Isetts BJ, Schondelmeyer SW, Arts MB, Lenarz LA, et al. Clinical and economic outcomes of medication therapy management services : The Minnesota experience. J Am Pharm Assoc. 2008;48:203-211

## > Section 11 – References

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